DC Fire & EMS Patient Care Policies:
EMS Patient Care Report

Note Well: *This protocol is intended to serve as general policy for the completion and channeling of the patient care report and to acknowledge the responsibility of the provider to properly document each patient contact.*

I. Policy

1. A patient care report will be completed for every patient contact. The pre-hospital provider is responsible for maintaining a record of every dispatched response. The patient care report is a medical record and the primary source of information for continuous quality improvement review. Pre-hospital care personnel shall be responsible for providing clear, concise, complete and accurate documentation. When a patient is transported, the patient care report will be delivered with the patient to the receiving hospital.

2. Completion of the patient care report for all EMT-B, EMT-I and EMT-P contacts will be as follows:

   A. In the event that a non-transporting and transporting ALS provider make patient contact simultaneously, one patient care report is adequate and it is generally completed by the transporting provider.

   B. If a non-transporting ALS provider arrives on scene prior to the transporting ALS unit, a patient care report will be generated by the non-transporting ALS provider, even if nothing more than a primary assessment has been done.

3. Before leaving, the providers will confer with the Receiving Hospital R.N. or physician and ensure that information needed for continuing care of the patient has been provided.

4. One (1) copy of the patient care report will be left at the Receiving Hospital.

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